Discomfort Survey

Based on your average workday, please complete the ***Discomfort Survey***. Fill in all of the boxes below. Please respond honestly and thoughtfully. **Your responses are anonymous.**

THANK YOU!

Date:	/ /		
Handedness:	Right	Left	Ambi
Line/Work Unit:			
Operation/Task:			

Rate discomfort for each region by writing the number (0 to 3 in the box.)

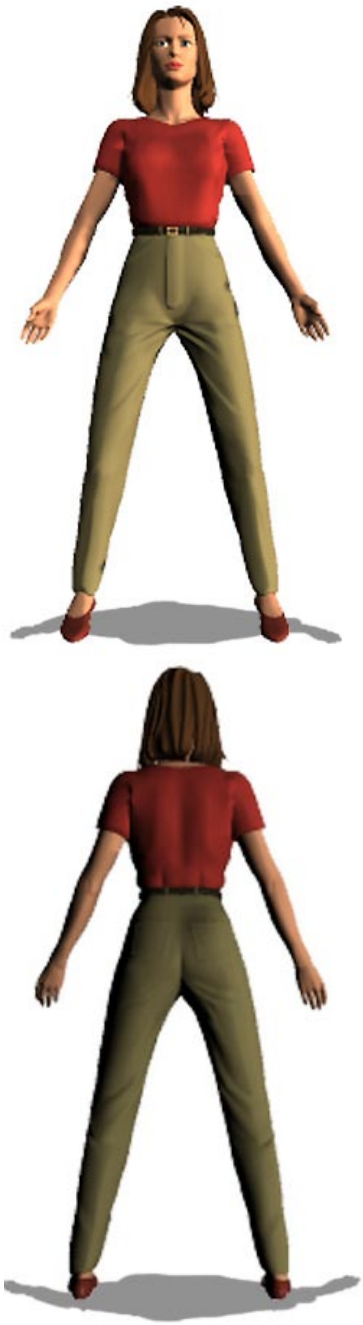
0=NONE/ MINIMAL: No discomfort at all. Some discomfort, able to reasonable cope with discomfort while performing general tasks

1=MODERATE: Moderate discomfort, some difficulty in performing general activities.

2=SEVERE: Significant difficulty in performing general activities.

3=MAX: Maximum discomfort (unable to function, admitted to the hospital.)

	BODY PART	Left	Right
A	Head/Neck/Eyes	___	___
B	Shoulder/Upper Back	___	___
C	Low Back (Mid/Low)	___	___
D	Arms/Elbows	___	___
E	Hands/Wrists/ Fingers	___	___
F	Legs/Feet	___	___
	TOTAL SCORE	___	___



Please respond to questions below (circle response):

How physically hard do you rate your work?	Easy	Moderate
	Hard	Very Hard
How much energy do you have left after at the end of your shift?	Lots	Some
	Little	None

OVER FOR ADDITIONAL COMMENTS

Please list suggestions to make your work more comfortable, safe and productive.

1.

2.

3.

4.

5.